CHIP Health Plan Selection Form

8-07

Once you have chosen a health plan, please mail or fax this form to your HPR (Health Program Representative). Or, e-mail chiphpr@utah.gov with your plan choice and the information below. *(Please print clearly)*

Case #		
Name of Parent/ Guardian	(First Last)	Date of Birth
Name(s) of child/ children	(First Last)	Date of Birth
	(First Last)	Date of Birth
	(First Last)	Date of Birth
	(First Last)	Date of Birth
	(First Last)	Date of Birth
Contact Information	(Address, City, State, Zip)	
	(Daytime Phone)	(Cell phone)
	(E-mail address)	
My Choice of Health Plan	☐ PEHP ☐ Molina	

Note: You must stay with your selected health plan through June 30 of each year.

Return to:

BMHC CHIP HPR, PO Box 143108 SLC, UT 84114-3108

Fax: 801-237-0743
E-mail: chiphpr@utah.gov

Name(s) of child/ children:	(First Last)	Date of Birth
	(First Last)	Date of Birth
	(First Last)	Date of Birth
	(First Last)	Date of Birth
	(First Last)	Date of Birth